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**Health Care Reform**  
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*Robin Lunge, Director*

Consent Policy Public Hearing  
4<sup>th</sup> Floor Conference Room  
Pavilion Building, 109 State St, Montpelier

January 27, 2014  
9:00 a.m. – 11:00 a.m.

## MINUTES

### **Meeting Attendees:**

Justin Bell, Visiting Nurse Association; Anne Cramer, Primmer, Piper, Eggelston & Cramer; Martha Csala, Agency of Human Services-AAG; Michael DelTrecco, Vt. Association of Hospitals and Health Systems; John Evans, VITL; Michael Gagnon, VITL; Robert Gibson, VITL; Allen Gilbert, ACLU; Paul Harrington, Vt. Medical Society; Keith Jones, Primmer; Kaili Kuiper, Vt. Legal Aid/Health Care Advocate; Robin Lunge, Agency of Administration; Steve Maier, Dept. of Vt. Health Access; Nancy Marinelli, Dept. of Aging and Independent Living; Marisa Melamed, Agency of Admin.; Howard Pallotta, DVHA; Julia Shaw, VLA/HCA; Heather Skeels, Bi-State Primary Care Association; Susan Zimmerman, VITL

### **1. Welcome & Objective**

*Introduction from Robin Lunge (Director of Health Care Reform, Agency of Administration).*

Robin states the purpose of the meeting is to consider potential changes to the existing consent policy. Copies of the draft changes and meeting materials are available at the meeting and online at <http://hcr.vermont.gov/consentpolicy>. John Evans (VITL) and Paul Harrington (VMS) are here to present on what is proposed. Robin outlined next steps in the process: additional written comments are to be submitted by February 3, 9:00 a.m. to [marisa.melamed@state.vt.us](mailto:marisa.melamed@state.vt.us); Director Lunge will bring recommendations to Secretary of Administration Jeb Spaulding, who will make a decision on behalf of the administration. The administration will bring its opinion to the Green Mountain Care Board (GMCB) for consideration February 13 and the GMCB is tentatively scheduled to vote on the change February 27.

### **2. Proposal**

*Consent policy proposed changes from Paul Harrington, speaking from his role as Executive Vice President of the Vermont Medical Society. Paul is also chairman of the board of VITL.*

Paul Harrington, along with Chuck Podesta (Chief Information Officer, Fletcher Allen Health Care & VITL Board Vice Chair) and Peter Cobb (Executive Director, VT Assembly of Home Health and Hospice Agencies) submitted a memorandum dated October 16, 2013 to Secretary Spaulding and GMCB Chair Al Gobeille regarding the request for GMCB revisions to the GMCB-approved October 25, 2012, Revised Updated Policy for Patient Consent of Provider Access to the Vermont Health Information Exchange

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(HIE) network. Mr. Harrington applauds VITL for the enormous progress they have made toward the goal of ubiquitous medical records. He states the current consent policy is an impediment to achieving this goal. The change in 2012 went from global consent to consent provider-by-provider. To illustrate, the American Medical Society (AMA) commissioned a study by the Rand Institute. The study showed that the greatest provider satisfaction comes from providing high quality care to their patients, while the greatest dissatisfaction comes from the administrative burden of managing electronic health records (EHR). Without changing the consent policy we will not be able to fully benefit from the implementation of EHR and the HIE. Mr. Harrington requests the support of Secretary Spaulding.

*John Evans, CEO VITL, opens [VITL presentation](#), slides 1-4.*

Why VITL exists: Hospitals, independent physicians, trade associations and health systems, coming together toward the goal of allowing information to follow the patient through their health care and flow from encounter to encounter. Today, VITL allows for an exchange of health information, connecting electronic records to the HIE. In the future, the goal is to also use the information for analytics purposes, similar to the Blueprint for Health, with an objective of improving population health. VITL is a 501(c)(3) not for profit organization, designated by the legislature as the entity responsible for operating a health information exchange network for the State of Vermont. The current consent policy is a provider-by-provider organization consent. The requested change shifts from “by provider” to “global opt-in.” Please see VITL slide 4 for the Rationale.

*Rob Gibson, VITL, on Pilot Programs, slides 5-8.*

VITLAccess is the secure internet web portal that allows a provider to log in and query for patient information. VITLAccess is real time 24/7, consent driven and web based. VITLAccess was piloted in seven diverse sites over the last eight months and received positive comments from most. Pilot sites were chosen to be geographically dispersed and to represent varying care settings.

*Michael Gagnon, VITL, on Federal Drug and Alcohol Abuse Treatment, 42 CFR Part 2, slide 9.*

Providers must have specific consent from the patient to access substance abuse records. How do you identify this information? Notes from a doctor may contain information that falls into this category. VITL does not want to accept that information currently, though this is not the long term plan. Slowly and carefully VITL will integrate that information through consent policy.

*Anne Cramer, VITL counsel, on legal implications, slide 10.*

Current policy was designed when we thought we could accommodate all of the health information. The changes remove drug and alcohol abuse treatment references and simplify the substance abuse language out of the policy.

*John Evans, VITL, concludes, slide 11.*

VITL is looking to change the policy before March 1 to allow implementation by April 1. An education/outreach/awareness campaign is planned for the information exchange. John concludes the remarks from VITL.

### **3. Questions of clarification on the proposal**

Robin asks if there are question for clarification.

*Kaili Kuiper, Vermont Legal Aid/Health Care Advocate:* Asks for clarification on what providers are able to do in the system vs. what they have permission to do.

Anne Cramer: For participating providers using the exchange, if they do not have patient consent they can only access information in “break glass” situations (emergency). If a patient has given permission

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providers will technically be able to “surf” for information. Patients may request an audit of who has viewed their information. An active consent flag must be set before providers can view the data.

*Julia Shaw, Vt. Legal Aid/Health Care Advocate:* If a patient were to request an audit what level of information would be available to them?

Michael Gagnon: Episode by episode you would only be able to view who viewed your record. Only the information being sent to VITL is available, i.e. only information that is “pushed” to us.

John Evans: VITL creates a commonality of information. Hospitals encourage that common information be shared.

Paul Harrington: Fletcher Allen/Dartmouth Hitchcock have a different type of system for sharing labs, imaging internally.

*Allen Gilbert, American Civil Liberties Union of Vermont:* In the master patient registry a flag placed shows if the patient has given consent or not given consent. Is the provider required to click a box that affirms they understand the consent policy every time they access the data?

John: Each provider organization enters into an agreement with VITL, a contractual agreement spelling out the prospective responsibilities. There is no specific box clicked at each episode consenting to using the information at each episode.

How does the liability flow? VITL has no statutory shielding from liability?

Anne: Correct

John: 24 hour monitoring of the system. Emergency situations are audited.

*Kaili Kuiper, VLA/HCA:* If someone specifically says they are not going to opt-in, his or her information can still be access during an emergency?

Michael: Clarifies there are two actions 1) the person just hasn’t done anything about it or 2) the person has signed that they do not consent. The result is the same.

Can two providers exchange information without viewing the database?

John: Yes there is a secure email system that needs to be installed at both ends. Only 72 individuals in Vermont have asked for the technology at this time.

How would a notification work without using that system? How do providers receive the alert from the ENS?

John: Not yet standing up yet. There are a couple of ways to stand this up.

*Julia Shaw, VLA/HCA:* Asks for a point of clarification on page 5, bullet point F of the draft proposal.

Michael: If two providers do not have access they cannot share information through the system.

*Allen Gilbert, ACLU:* The lay public sees this as an exchange, rather than a system that is storing data. When the VITL system does an exchange, the VITL system itself will contain patient records. How is the information that VITL holds updated or not updated?

Michael: The system was always intended to aggregate information sent to it by the provider, it performs transactions and aggregation.

That may have been the intention but that is not the way people understood the system. The general perception is of an exchange, not a place to store information. In a “break the glass” situation what will happen with the information?

Michael: There is never any pulling of information; providers can only access what is given on VITL. Data is stored in separate secure “vaults” in the VITL system for each provider and is not aggregated from across all provider “vaults” until someone queries for it. Before Medicity, GE Health Care did not have the capability to collect and aggregate patient information. They did not do it not because they did not intend to do it, but because they were not capable of doing it.

*Allen Gilbert, ACLU:* In the current repositories, who has legal responsibility?

John: VITL, Medicity, originating organizations. Medicity is the number 1 or 2 provider of HIT in the country utilized by 25% of all the hospitals in the USA. The system exceeds HIPAA requirements and has never had a breach.

*Julia Shaw, VLA/HCA:* Asks a question about intent vs. capability. If we take drug and alcohol abuse treatment out of the policy now because we can't do it and then later add it back in, what happens to the people now who have opted in?

Anne: Since the federal regulations will likely remain the same, it will need to be a separate consent process for substance abuse treatment records.

*Martha Csala, AHS-AAG:* In the pilot has anyone made a comment about 42 CFR Part 2?

VITL: It has never been called out.

#### **4. Public Comment Period**

Robin asks if anyone would like to share verbal comments.

[Allen Gilbert, ACLU, reviewed his submitted written comments.](#) He states the public perception is that medical records are not secure; the public will be skeptical and undermine the success of the system. Perception forms public opinion. He recommends strict regulations to bring a heavy hand on those who access records without consent or in the proper manner. He cites a case in Bennington of a woman who had her records and her children's records accessed over 100 times. The offender was charged with a misdemeanor, given a suspended sentence, and is still working today as a technician in the health field 15 miles from Vermont. You cannot convince the victim that records are secure. The ACLU comments outline four privacy concerns and four requirements that must be included in the policy in order for the ACLU to support the change.

Paul Harrington, VMS, supports first bullet point of the ACLU recommendations.

The administration also received [statements of support from Rainbow Pediatrics patients](#) who were part of the pilot project; these comments are posted on the webpage.

Meeting adjourned.

Please note:

All documents related to the meeting, including agenda, minutes, and written comments are posted at <http://hcr.vermont.gov/consentpolicy>.

Important dates:

- February 3, 9:00 a.m. – Written comments due to [marisa.melamed@state.vt.us](mailto:marisa.melamed@state.vt.us).
- February 13, 1:00-5:00 p.m. – The administration will bring its recommendation to the Green Mountain Care Board Meeting. The GMCB Meeting will be followed by a public comment period to the GMCB.
- February 27, 1:00-5:00 p.m. – The GMCB is currently scheduled to vote on a decision.